

# **Policy Issues Affecting Maine Hospitals**

**Medicare Cost Report Boot Camp  
Healthcare Financial Management Association  
December 11, 2009  
South Portland, ME**

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# Overview of Today's Presentation

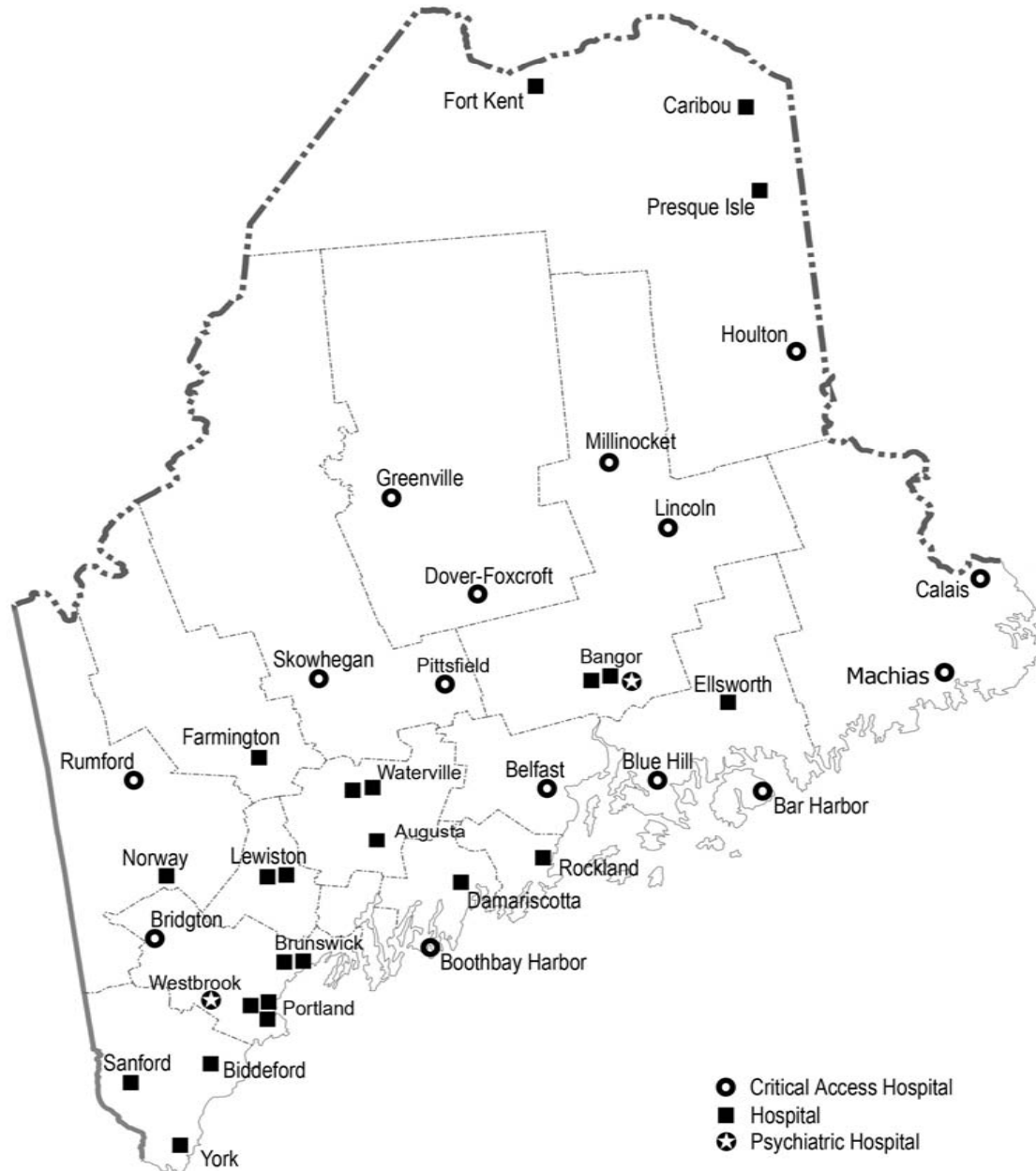
- **Overview and distribution of Maine's Hospitals**
- **Review of major policy issues affecting Maine's hospitals**
  - **Economic stress**
  - **Uncompensated costs of treating the uninsured**
  - **Transparency and payment reform**
  - **National health care reform**
  - **Community benefit reporting and the IRS Form 990**



## **Overview of Maine's Hospitals**

- **39 acute care and specialty hospital**
- **Majority are private non-profit facilities**
- **Three are government run, one is organized through a regional Hospital Administrative District, and one is municipally owned**
- **15 are Critical Access Hospitals**
- **Maine hospitals employ 40% of the physicians in the state and provide more than 22,000 full time equivalent jobs (MHA)**





## Comparative Hospital Statistics

	<b>Maine</b>	<b>New England</b>	<b>U.S.</b>
<b>Beds per 100 square miles</b>	<b>10.1</b>	<b>51.5</b>	<b>21.1</b>
<b>Average length of stay</b>	<b>4.8</b>	<b>5.2</b>	<b>5.1</b>
<b>Beds per 100, 000 residents</b>	<b>2.7</b>	<b>2.4</b>	<b>2.7</b>
<b>Admissions per 1,000 residents</b>	<b>114.5</b>	<b>116.0</b>	<b>119.2</b>
<b>Inpatient days per 1,000 residents</b>	<b>641.8</b>	<b>647</b>	<b>666.8</b>
<b>ED visits per 1,000 residents</b>	<b>551.4</b>	<b>448.0</b>	<b>388.0</b>

Source: AHA Hospital Statistics, 2007 Ed.



## **Impact of the Economy on Hospitals**

- **The economy has taken its tolls on hospitals, and their patients and communities (AHA):**
  - **Proportion of ED patients without insurance has increased**
  - **Higher proportion of patients are unable to pay for care**
  - **More patients covered by Medicaid and other public programs for the low income populations**
  - **Fewer patients are seeking inpatient and elective services**
  - **Community need for subsidized services is increasing while charitable contributions to support such activities are declining**



## **Impact of the Economy (continued)**

- **Nationally, 9 out of 10 hospitals have made cutbacks to address economic concerns (AHA)**
  - **Almost all have reduced staff**
  - **80% have cut administrative expenses**
  - **20% have reduced key community services such as behavioral health, post acute care, patient education, and other services requiring subsidies**
  - **70% report a decline in overall financial health**
  - **80% report cutting capital spending for facility upgrades, clinical technology, or information technology**
  - **80% report an increase in physician seeking financial support from hospital including on call pay or employment**



## Uncompensated Hospital Care Costs

- **The economy has driven increases in the number of people unable to pay for their care**
- **Hospitals are experiencing an increase in the demand for free care**
- **Cost of uncompensated care has been increasing from \$4 billion (5.1% of costs) in 1980 to \$36.4 billion (5.8% of costs) in 2008 (AHA)**
- **AHA estimates that Medicare hospital margins will be a negative 6.9% in 2009 (an all time low)**
- **Medicaid shortfalls amounted to \$10.4 billion in 2007 (AHA)**



## Transparency

- **LD 724: Directs MHDO and Governor's Office of Health Policy and Finance to create a working group to provide transparency concerning operating expenses for hospitals**
- **LD 1205: Health Bill of Rights requires transparency on the part of health insurers to clearly state what is covered and what is excluded**
- **LD 1444: An Act to Protect Consumers and Small Businesses from Rising Health Care Costs calls for transparency of health care costs and payment reform with health care providers**



## **LD 724: Hospital Transparency**

- **Directs MHDO and Governor's Office of Health Policy and Finance to create a working group to provide transparency concerning operating expenses for hospitals**
- **Duties of working group: Examine and make recommendations for hospital data reporting to provider greater transparency**
- **Report to the Legislature by January 2010**
- **Recommend additional legislation to improve transparency**



# **LD 1205: Health Insurance Transparency**

- **Insurers must:**
  - **Post 5 top selling plans to individuals/small businesses on a public website purchase them**
  - **Provider consumers with better information on payment or denial of claims**
  - **Cover prescription drugs that were covered by a previous insurance company**
  - **Makes public information to support rate increases**
  - **Other public disclosure protections**
- **Requires the Superintendent of Insurance to do conduct market examinations of health insurance companies at least once every 5 years**



## **LD 1444: Payment Reform**

- **Part A directs Advisory Council on Health Systems Development to develop recommendations on payment reform**
- **Part B directs Superintendent of Insurance to adopt rules for physician performance measurement, reporting, and tiering programs**
- **Part C requires DHHD to post on publicly available website IRS Form 990 and other forms already filed by hospitals with the Department**



## **LD 1444: Proposed Report to Legislature**

- **Support integrated systems of care and payment**
- **Promote patient-centered approach to service payment and delivery**
- **Encourage/reward disease prevention/management**
- **Promote value of care over volume to lower costs**
- **Support payments and processes that are transparent, understandable, and simple to administer**
- **Balance interests of patients and providers against the need for change**
- **Encourage multiple community-based models of**



## Medicare Payment Reform

- **State payment reform occurs in the context of national reform and concerns about Medicare**
- **Part A Trust Fund projected to be insolvent by 2019**
- **Part B costs/premiums consuming an increasing portion of social security payments**
- **Health outcomes vary widely from place to place and are inferior to many other developed countries**
- **Criticized for not paying its fair share of costs and encouraging cost shift to other insurers and patients**



## National Health Reform

- **Lots of action, still too soon to tell what will happen**
- **Hopefully, an increase in coverage and a reduction in the number of uninsured**
- **Expectation that it will reduce the uncompensated care costs of hospitals, particularly for charity care**
- **Will not eliminate it (similar to implementation of Medicare and Medicaid in 1965)**
- **Must watch reimbursement policies**
- **Some advocates are questioning tax exemptions to hospitals if charity care is reduced/eliminated**



## **Context for Community Benefit Reporting**

- **Catholic Health Association/VHA community benefit reporting standards**
- **Senate Finance Committee interest in hospital charitable activities**
- **Interest in setting minimum community benefit standards – minimum 5% has been suggested**
- **IRS 2006 Hospital Compliance Study**
- **IRS revisions to Form 990 and Schedule H effective for Tax Year 2009**



## What are Community Benefits?

- **Programs or activities providing treatment or promoting health in response to identified community need**
- **Key criteria**
  - **Generates a low or negative margin;**
  - **Responds to needs of special populations;**
  - **Supplies a program or service that would likely be discontinued if based solely on financial criteria;**
  - **Responds to public health needs; or**
  - **Involves education or research that improve overall community health**



## **Community Benefits (continued)**

- **Key questions to determine whether a program or activity is a community benefit:**
  - **Does the activity address an identified community need?**
  - **Does the activity support the CAH's community-based mission?**
  - **Is the activity designed to improve health?**
  - **Does the activity produce a measurable community benefit?**
  - **Does the activity survive the "laugh" test?**
  - **Does the activity require subsidization?**
  - **Given limited resources, would residents chose this activity to improve the health of their community?**



# Community Benefit: Patient Care Services

- **Charity care**
  - Free and discounted services provided to persons who cannot afford to pay and meet criteria for financial assistance; does not include bad debt
- **Government-Sponsored Health Care**
  - Unpaid costs/shortfalls for care provided to beneficiaries covered by Medicaid, SCHIP, local or state public or indigent care programs, and Medicare, where appropriate. Excludes contractual adjustments



## **Community Health Improvement Services**

- **Community health education**
- **Community-based clinical services**
- **Support groups and self-help programs**
- **Health care support services**
- **Social services programs for vulnerable populations in the community**
- **Examples: Health fairs, smoking cessation programs, free clinics, transportation programs to enhance access to care**



## **Health Professions Education**

- **Physicians / medical students**
- **Nurses / nursing students**
- **Other health professional education**
- **Scholarships / funding for professional education**



## **Subsidized Health Services**

- **Services provided to the community that are not expected to be self sustaining and may include:**
  - **Emergency and trauma care services**
  - **Hospital outpatient services**
  - **Women's and children's services**
  - **Renal dialysis services**
  - **Continuing care**
  - **Behavioral health services**
  - **Palliative care**



## Research

- **Clinical research**
- **Community health research**
- **Examples: Studies on health issues for vulnerable populations, research studies on innovative health care delivery models, unreimbursed/unfunded costs of studies on therapeutic protocols**



# **Financial and In-Kind Contributions**

- **Cash donations**
- **Grants**
- **In-kind donations**
- **Cost of fund-raising for community programs**



## **Community Building Activities**

- **Physical and environmental improvements;**
- **Economic development**
- **Support system and workforce enhancement**
- **Leadership development/training for community members**
- **Coalition building**
- **Community health improvement advocacy**



# Community Benefit Operations

- **Includes the costs associated with community benefit strategy and operations, including:**
  - **Dedicated staff**
  - **Community health needs/health assets assessment**
  - **Other resources**



## What Doesn't Count?

- **Programs or activities that:**
  - A “prudent layperson” would question
  - Do not involve hospital resources
  - Benefits the hospital more than the community (e.g., some marketing activities)
  - Are not available to the public
  - Represent a normal “cost of doing business”
  - Are associated with current standards of care



## **IRS Form 990, Schedule H**

- **Based on CHA standards**
- **Mandatory for tax-exempt hospitals – 501(c)3**
- **Optional but not required for all other hospitals**
  - **Not a bad idea for those not required to complete Form 990**
- **Tax year 2009 (returns filed 2010), hospitals must complete the full form with data on the value and scope of community benefit activities and charity care**



## **Six Parts of Schedule H**

- **I: Charity care and certain other community benefits**
- **II: Community building activities**
- **III: Bad debt, Medicare, and collection practices**
- **IV: Management companies and joint ventures**
- **V: Facility Information**
- **VI: Supplemental information**



## **Policy and Reporting Issues**

- **Charity care, bad debt, and billing activities will be the focus of attention**
- **Efforts to set minimum standards**
- **Substantial administrative burden of CB reporting**
- **“Legacy” activities may contribute comparatively little to the health of the community**
- **Attention to CB reporting may shift focus from strategy to accounting exercise**
- **Although not required to report to the IRS, public and other hospitals may feel pressure to**



## Resources

- **CHA's *Community Benefit Strategies***
- **California Hospital Association's *Voluntary Principles and Guidelines for Assisting Low-Income Uninsured Patients***
- **AHA's *Hospital Billing and Collections Practices: Statement of Principles and Guidelines***
- **HFMA's *Statement 15 Regarding Reporting Charity Care and Bad Debt***
- **Public Health Institute's *Advancing the State of the Art in Community Benefit: A User's Guide to Excellence and Accountability***



## What Can Hospitals Do?

- **Revisit community benefit activities and strategies**
- **Focus on critical community needs – conduct regular needs assessment and involve community**
- **Eliminate/revise legacy activities that do not contribute directly to identified community needs**
- **Prioritize activities and community benefit spending**
- **Track impact and outcomes of activities**
- **Consider using funds saved from reductions in uncompensated care to focus on community needs**

